Scott F. McLaughlin Speech & Hearing Clinic

Payment Plan Contract

10/2017

Client Name / Parent / Guardian:____

Address: ____

City: ________________________________ State: _____________ Zip Code: __________

Phone: ___________________________ E-Mail: ____________________________________

Total amount owed (beginning balance)………………………..…………………….$______________

Payment Date	Payment Amount	Balance

I, the undersigned client/parent/guardian, agree to pay the above instalments to the Scott F. McLaughlin Speech & Hearing Clinic. I understand the consequences that will be brought against me if the contract is violated. The penalties could include: a $25.00 late fee added to one or more of the payments, or termination of services/treatment provided by the Scott F. McLaughlin Speech & Hearing Clinic. I also consent to be contacted at the email address and telephone number provided above for notification of upcoming payment dates as well as reminders should there be a late payment.

______________________________ ______________________________ ______________

Name Signature Date